A CASE OF SURGICAL KIDNEY WITH SPECIMEN.*

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The patient is a spare man, 22 years of age, single. He came under my observation July 30, 1907, with the following history.

Since his tenth year of age he had had occasional attacks of scalding urine and pain in the penis, and attacks of pain in the region of the left kidney. The intervals between these attacks had been a month, sometimes longer; the duration of the attacks had varied from a few days up to ten days. His urine is said always to have had a bad odor, even when fresh. Its sediment is described by the family as having been pinkish-brown and coarse. Exposure to cold and undue fatigue are mentioned as exciting causes of these occasional attacks.

In the latter part of May he developed a urethritis after an incubation of one week. He took capsules of his own prescribing and the discharge ceased in a few days. About a week later, namely, on June 6th, while surveying above ground in good weather, he developed great frequency of urination with tenesmus. That night he had coitus. The discharge reappeared the following morning; the frequency and tenesmus increased, and, forty-eight hours later, terminal bleeding was noticed. The following day (June 9) considerable pain developed in the left kidney region. He went to bed (June 10) and remained abed for three weeks during which time the frequency, tenesmus and kidney pain continued, and a milky urethral discharge was apparent off and on. Finding that he was not improving he decided to go back to work. He stayed at work as long as he could, which

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was one week, when he was again compelled to take to his bed. Twelve hours later (on the morning of July 9) he was awakened with sudden, very severe pain in the left kidney region, and he noted that his urine was thick and extremely offensive. The severe kidney pain became constant and continuous; the frequency of urination and the tenesmus increased. After he had been in bed one week, the discharge ceased; but all the other symptoms continued unabated. Between July 8 and July 30, when he was referred to me, he had lost 32 pounds.

He gave no history of chills; but he had had profuse sweats with undoubted rise of temperature.

In childhood he had had pneumonia (when two years old) from which he had apparently fully recovered, measles and whooping cough. There is no history of scarlet fever, typhoid fever nor gastro-intestinal disturbances. There is no personal nor family history of tuberculosis.

The patient was deplorably anemic and emaciated when he came under observation, on July 30. The urine was loaded with pus of a dirty, grayish color and had a putrid odor. The left kidney was palpable and tender. After the patient had been carefully nursed for one week, a rapid nephrotomy for drainage was performed. A large pus sac was found, from which a volume of extremely offensive pus was evacuated. The patient rallied satisfactorily from the operation and began at once to gain in health and strength. After about two weeks, however, the kidney tissue showed a persistent tendency to close, and the urine, which had been perfectly clear during those two weeks, again became charged with pus from the diseased kidney. All attempts to maintain drainage by way of the loin failed. Finally, on October 29, the patient being in fairly good general condition, nephrectomy was performed. The shock was profound; but he responded to the active treatment employed and rallied within four hours. He is making a satisfactory recovery.

The uranalysis prior to the nephrotomy was as follows: normal amber color; turbid; a heavy, grey precipitate; strongly acid; albumin present; no sugar; no indican; urea, 11 gr. per oz.; a small amount of mucus; a large amount of pus forming almost the whole precipitate; no blood; no casts; very few bladder or urethral epithelia; large numbers of bacteria; no crystals; abundant amorphous deposit. The bacteriological examination

of the heavy sediment showed short chains of streptococci; staphylococci; a few diplococci; no gonococci; no tubercle bacilli.

The pathological examination, made by Dr. Sondern, reads as follows:

"The capsule is not thickened, but is infiltrated with red blood cells and is separated from the cortex in places by considerable hemorrhage. There are large areas of hemorrhage in the cortex and medulla near the pelvis. The blood vessels are congested. The glomeruli are congested and some of the capsules of Bowman contain blood. The cells in some of the convoluted tubules are swollen and almost occlude the lumen of the tube. In other tubules the epithelium is disintegrating. Section into the pelvis shows desquamation of the epithelium. Beneath the epithelial line is a thick zone of round cells which is vascular and congested. Beneath the zone of round cells is a thick layer of dense fibrous tissue which contains many accumulations of inflammatory round cells. There is some superficial necrosis and hemorrhage in the pelvis. No tubercles found. Diagnosis: Chronic and acute parenchymatous nephritis; ulcerative and hemorrhagic pyelitis."

The precise etiologic factor could not be determined. With the history before us, however, it is fair to assume that this patient had been carrying a chronic pyelitis (probably due to the colon bacillus) for ten years, and that from his posterior urethritis he developed an ascending infection that brought about the lesion that endangered his life.